Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 261-7083
Phone #: (608) 266-2112

Ship To: 1400 E. Washington Avenue
Madison, WI 53703
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

PHARMACY EXAMINING BOARD

CERTIFICATE OF STUDENT NON-ACADEMIC INTERNSHIP IN THE PRACTICE OF PHARMACY

APPLICANT: Complete this section and submit to supervising pharmacist for completion. Form must be returned directly from the supervising pharmacist to the Department at the above address. This form may be copied and additional copies submitted if necessary.

Last Name | **First Name** | **MI** | **Former / Maiden Name(s)**

Address: (number, street, city, zip code)

Date of Graduation: ___ / ___ / ____

SUPERVISING PHARMACIST: Complete this section and return directly to DSPS: You may fax/email with facility cover sheet/letter to: (608) 261-7083 or dspscredpharmacy@wisconsin.gov.

Name of Supervising Pharmacist

Supervising Pharmacist WI License Number ____ - **40**

Internship Location:
(name, number, street, city, zip code)

I have directly supervised the applicant for a total of _____ hours in an internship in the practice of pharmacy after the applicant successfully completed his or her second year in and was enrolled at a professional Bachelors of Science degree in pharmacy or Doctor of Pharmacy degree granting institution located in this or another state. I have kept a written record of the hours and location worked by the applicant under my direct supervision.

The undersigned, state that the facts and statements herein contained are true and correct based upon personal knowledge of the undersigned.

Signature of Supervising Pharmacist

Date ___ / ___ / ____